

**Title:** INTRAVENOUS IMMUNE GLOBULIN FORMULATION  
CONTAINING A NON-IONIC SURFACE ACTIVE AGENT  
WITH IMPROVED PHARMACOKINETIC PROPERTIES

**FIELD OF THE INVENTION**

The present invention relates to an improved method and immune globulin formulation containing a non-ionic surface active agent to prolong the serum half-life and to alter the immunomodulatory effect of immune globulin.

**BACKGROUND OF THE INVENTION**

Immune globulins (also known as immunoglobulins or antibodies) are proteins produced by lymphoreticular tissues. There are 6 known classes of immune globulin: IgG, IgM, IgA, IgD, IgE and secretory IgA. IgG (also known as gamma-globulin) is the most abundant and the most therapeutically relevant class of immune globulin. The primary function of immune globulins is to specifically recognize and bind antigens through reversible bonding thereby facilitating the immune systems ability to eliminate antigens.

IgG is a glycoprotein of approximately 150,000 Daltons consisting of 2 "heavy" (gamma) chains and 2 "light" (kappa or gamma) chains held together by disulphide as well as weak covalent bonds. Within the class of IgG, there are 4 subclasses of IgG1, IgG2, IgG3 and IgG4 comprising about 70%, 15%, 10% and 5% of total IgG in normal human serum respectively. These subclasses possess minor antigenic differences among their "heavy" chains resulting in distinct biological actions.

There are principally two types of immune globulins that are available as therapeutic agents: standard immune serum globulin preparations for general use, and immune globulin preparations that recognize specific antigens for use in specific disorders. Commercial examples of products in the former category include numerous brands of intravenous immune globulin (Gamimune N® by Bayer; Sandoglobulin® by Sandoz; Gammar-IV® by Armour) as well as intramuscular immune globulin (Gamastan® by Cutter; Gammar® by Armour). Examples of

- 2 -

products in the latter category are hepatitis B immune globulin (H-BIG® by Abbott; Hep-B-Gammagee® by MSD; HyperHep® by Cutter), varicella zoster immune globulin (VZIG by Massachusetts Public Health Biologic Labs.), cytomegalovirus immune globulin (CytoGam® by Connaught) and  
5 Rh immune globulin (WinRho® and WinRho SD® by Cangene; HypRho-D® by Miles; Gamulin Rh® by Armour; RhoGAM® by Ortho Diagnostics). The primary therapeutic basis for immune globulins is passive immunity conferred to the recipient through the direct introduction of extraneous "ready-made" antibodies. The major clinical utilities of immune  
10 globulins are prophylaxis and/or treatment of antigen-associated disorders.

Immune globulins may be prepared by isolation of natural immune globulins from mammalian serum. Immune globulins prepared using Cohn's cold ethanol fractionation method suffers from  
15 relatively low product yield and IgG purity. The resultant product contains significant amounts of aggregated immune globulin which combines with complement (also termed anticomplementary activity) and produces adverse reactions in recipients if given by intravenous injection or infusion (see Huchet, J. et al., *Rev. Fr. Transfus.* 13:231, 1970;  
20 Chown, B. et al., *Can. Med. Assoc. J.* 100:1021, 1969; Barandun, S. et al., *Vox Sang.* 7: 157-174, 1962). Correspondingly, these immune globulin preparations must be injected intramuscularly (therefore termed intramuscular immune globulin). Intramuscular injections are painful. Drug absorption and peak levels of immune globulin (hence onset of  
25 therapeutic action) are slow, and approximately half of the injected dose is lost due to local proteolysis and incomplete absorption. Significant amounts of IgA and IgM are also present in Cohn-prepared intramuscular immune globulin preparations which can cause anaphylactic reactions in certain recipients.

30 Compared with other parenteral routes, such as those just discussed, intravenous injection or infusion of immune globulin is the preferred route of drug administration in the clinical setting due to instant bioavailability and rapid onset of therapeutic protection.

- 3 -

Intravenous immune globulin products differ from intramuscular products in two fundamental ways. First, an intravenous preparation must contain a significantly smaller amount of aggregated immune globulin molecules (over about 94% monomeric immune globulin) thereby causing fewer anticomplementary adverse reactions. Second, the IgG content and product purity of intravenous immune globulin products are significantly higher (over about 95% IgG content) than intramuscular products. The low level of contamination with IgA or IgM in intravenous immune globulin (less than about 40 ug/mL) is also associated with lower incidences of adverse events such as anaphylactic reactions especially in agammaglobulinemic recipients.

Improved methods involving further purification of the Cohn immune globulin fractions (see Jouvenceaux, A. et al., *Rev. Fr. Transfus.* 12 (suppl.): 341, 1969) were developed to render immune globulin produced from cold ethanol fractionation suitable for intravenous administration. Ultracentrifugation of the immune globulin-containing fraction, or treatment of immune globulin with pepsin, plasmin, a sulfitolytic agent or beta-propiolactone, reduces the anticomplementary activity of the final preparation (see U.S. Patent No. 4,160,763; Barandun, S. et al., *Monogr. Allergy* 9: 39-60, 1975; Stephan, *Vox Sang.* 28: 422-437, 1975; Wells, J.L.V. et al., *Austr. Ann. Med.* 18: 271, 1969; Baumgarten, W. et al., *Vox Sang.* 13: 84, 1967; Merler, E. et al., *Vox Sang.* 13: 102, 1967; Sgouris, J.T. et al., *Vox Sang.* 13: 71, 1967; Barandun, S. et al., *Vox Sang.* 7: 157-174, 1962; Nisonoff, A. et al., *Science* 132: 1770-1771, 1960). U.S. Patent No. 3,903,262 describes the reduction of intermolecular disulphide bonds of immune globulin and alkylation of the resultant sulfhydryl groups. Schura of Germany also developed an immune globulin for intravenous injection by adsorption of immune globulin onto hydroxy-ethyl starch. However, these approaches are often technically unfeasible for manufacturing or residual reactants in the final preparation have been shown to cause undesirable outcomes such as a reduction in serum half-life of the immune globulin and elicitation of immunogenic reactions in recipients.

Further improved chromatographic techniques (e.g. using DEAE-Sephadex ion-exchange columns in combination with ultrafiltration) were also developed for the manufacture of immune globulins from human plasma to produce immune globulins suitable for intravenous injection or infusion (see Canadian Patent number 1,168,152; Canadian Patent number 1,201,063; Cunningham, C.J. et al., *Biochem. Soc. Trans.* 8: 178, 1980; Hoppe, H.H. et al., *Vox. Sang.* 25: 308, 1973; Hoppe, H.H. et al., *Münch. Med. Wochenschr.* 109: 1749, 1967; Baumstark, J.S. et al., *Arch. Biochem.* 108:514, 1964). The use of such chromatographic manufacturing processes also substantially increases product yield to over about 90%.

Immune globulin prepared by improved processes may be administered by intravenous injection or infusion as well as other parenteral routes. For instance, Cangene's WinRho® and WinRho SD® are produced using a proprietary anion exchange chromatographic process and are the only commercial anti-Rh<sub>0</sub>D immune globulin preparations that can be administered safely by intravenous injection or infusion to humans. This is due to their relatively higher IgG purity and monomeric protein content as well as lower IgA/IgM contamination.

Monoclonal immune globulins can be produced using recombinant and hybridoma techniques (see Canadian Patent number 1,303,534; Canadian Patent number 1,303,533; European Patent Application 87302620.7 published as EP 239,400; European Patent Application 93102609.0 published as EP 557,897; Fletcher, A. and Thompson, A., *Transfus. Med. Rev.* 9: 314-326, 1995; Alting-Mees, M. et al., *Strat. Mol. Biol.* 3: 1-9, 1990; Huse, W.D. et al., *Science* 246: 1275-1281, 1989; Sastry, L. et al., *Proc. Natl. Acad. Sci. USA* 86: 5728-5732, 1989). Similarly, binding partners or domains may also be constructed using recombinant DNA techniques to incorporate the variable regions of a gene encoding a specific antibody (see PCT Patent Application PCT/GB93/00605 published as WO 93/19172; PCT Patent Application PCT/GB93/02492 published as WO 94/13804; PCT Patent Application

- 5 -

PCT/EP90/01964 published as WO 91/07492; Bird et al., *Science* 242: 423-426, 1988).

Immune globulin preparations suitable for parenteral injection commonly consist of an immune globulin distributed in a physiologically compatible medium. This medium may be sterile water for injection (WFI) with or without isotonic amounts of sodium chloride. For example, the recommended diluent for reconstituting commercial intravenous immune globulins such as Iveegam®, Gammagard®, or, Venoglobulin®, is sterile WFI. Sandoglobulin® is supplied with 0.9% (w/v) sodium chloride solution as diluent (see Gahart, B.L. & Nazareno, A.R., *Intravenous Medications: a handbook for nurses and allied health professionals*, p. 516-521, Mosby, 1997). WinRho SD®, is reconstituted in 0.9% sodium chloride solution for intravenous injection. The immune globulin product by Schura (*supra*) is formulated as a solution of 165 mEq/L sodium ion and 120 mEq/L chloride ion with a final pH of 6.7. The Miles' intravenous immune globulin preparation, Gammimmune®, when constituted, has an osmolality of 278 mOsm/L and a pH of 4.0-4.5. U.S. patent Nos. 4,396,608 and 4,499,073 also disclose a low pH (3.5-5.0) and low ionic strength ( $\leq 0.001$ ) immune globulin formulation for intravenous injection. The globulin protein concentration in the above preparations ranges from 0.5% to 20%.

Carbohydrates and their derivatives such as glucose, maltose or mannitol may be included in immune globulin formulations to adjust the tonicity of the preparation. For example, maltose (10%) is included in Miles' intravenous immune globulin preparation, Gammimmune®, to achieve isotonicity. Sucrose (5%) is included in Sandoz's intravenous immune globulin preparation, Sandoglobulin® and in Armour's intravenous immune globulin preparation, Gammar-IV®. The commercial intravenous immune globulin preparation, Venoglobulin®, contains 50 mg/mL D-sorbitol.

Likewise, amino acids such as glycine or histidine may be added to improve storage stability of the protein. For example, glycine (0.3M) is included in commercial immune globulin preparations such as

- 6 -

American Red Cross' intravenous immune globulin preparations, Polygam® and Polygam S/D®; the intramuscular varicella zoster immune globulin preparation by Massachusetts Public Health Biologic Laboratories; and the intramuscular anti-Rh<sub>0</sub>D immune globulin preparations by Armour and Miles. U.S. patents Nos. 4,396,608 and 4,597,966 describe the use of glycine and histidine to stabilize immune globulin formulations. European Patent Application No. EP 392,717 describes the use of mannitol and glycine to stabilize and prevent aggregation of immune globulin in formulation.

10           The prolongation of storage shelf-life of immune globulin preparations may also be accomplished by the addition of preservatives including organic mercurial derivatives such as thimerosal.

Surface active agents (also termed surfactants or detergents) are compounds that can lower the surface tension of water. All surface active agents are amphipathic possessing a hydrophobic end (*e.g.* one or more hydrocarbon chain(s)) as well as a hydrophilic moiety (which may or may not be ionic). A surface active agent may be classified as anionic, cationic, or non-ionic depending on the nature of its hydrophilic moiety. Soaps with carboxylate or sulphonate groups carry net negative charges and are examples of anionic surface active agents. Benzalkonium, an N-benzyl quaternary ammonium chloride and an antibacterial agent, carries a net positive charge and is an example of a cationic surface active agent. A non-ionic surface active agent contains a neutral group such as a carbohydrate which can hydrogen-bond with water.

25           Tween® and Span® are two types of non-ionic surface active agent. Agents such as Span® are partial esters of common fatty acids and sugar alcohol anhydrides derived from sorbitol. Agents such as Tween® are derivatives of Span® products with polyoxyethylene chains attached to non-esterified hydroxyl groups. Their hydrophilic property is due to free hydroxyl and/or oxyalkylene groups, and their hydrophobic property is due to their long chain fatty acids. Examples of commonly used Span® type surface active agents are sorbitan monolaurate (Span 20), sorbitan monopalmitate (Span 40), sorbitan monostearate (Span 60),

sorbitan tristearate (Span 65), sorbitan monooleate (Span 80), and sorbitan trioleate (Span 85). A commonly used member of Tween® type surface active agent, Tween 80, is also known as Polysorbate 80, sorbitan mono-9-octadecenoate poly(oxy-1,2-ethanediyl) derivative, polyoxyethylene sorbitan monooleate, polyethylene oxide sorbitan monooleate, sorbothan monooleate, Sorlate, Monitan or Olothorb. Other examples of polyoxyethylene sorbitan surface active agents comprise polyoxyethylene sorbitan monolaurate (Tween 20 or 21), polyoxyethylene sorbitan monopalmitate (Tween 40), polyoxyethylene sorbitan monostearate (Tween 60 or 61), polyoxyethylene sorbitan tristearate (Tween 65), and polyoxyethylene sorbitan trioleate (Tween 85).

The safety of non-ionic surface active agents in mammals has been studied extensively and established. Previous acute toxicity studies indicated that the LD50 values for Tween® and Span® type non-ionic surface active agents in rats are relatively high at >15 g/kg for oral ingestion and >1.4 g/kg for parenteral injection (*J. Am. Coll. Toxicol.* 3: 1-82, 1984; Varma, R.K. et al., *Arzneimittelforschung* 35: 804-808, 1985; Farkas, W.R. et al., *Pharmacol. Toxicol.* 68:154-156, 1991). Subacute and chronic toxicity studies also showed minimal toxicity after administration of relatively high oral doses to rats (100-200 mg per kg body weight) (Nityanand, S and Kapoor, N.K., *Indian J. Med. Res.* 69: 664-670, 1979). A number of reproductive toxicology studies also did not identify a hazard with the clinical use of non-ionic surface active agents (Kitchin, K.T. and Ebron, M.D., *Toxicology* 30: 45-47, 1984; Ema, M. et al., *Drug Chem. Toxicol.* 11: 249-260, 1988; Gajdova, M. et al., *Med. Toxicol.* 3: 128-165 and 209-240, 1988).

The inclusion of surface active agents in protein drug preparations has been practised extensively to improve product stability in storage and/or to increase product solubility. A commercially available preparation of granulocyte colony stimulating factor, Neupogen®, contains 0.004% Polysorbate 80 to improve storage stability. Turbersol® is a sterile isotonic solution of Tuberculin in phosphate buffered saline containing 0.0005% Polysorbate 80 as a stabilizer.

- 8 -

With respect to immune globulin preparations, U.S. Patent No. 4,902,500 discloses immune globulin formulations with improved storage stability containing at least one polyoxypropylene-polyoxyethylene block polymer (Pluronic 68). PCT Patent Application FR93/00584 published as WO94/16728 describes the inclusion of Polysorbate 80 in a parenteral formulation of an anti-LFA-1 monoclonal antibody for stabilization purposes. U.S. Patent No. 5,215,743 describes the use of Polysorbate 80 to stabilize parenteral formulations of tumour necrosis factor (TNF).

U.S. Patent No. 5,151,266 teaches a method of treating antibodies with an anionic detergents such as sodium dodecylsulfate (sodium lauryl sulfate), cetyl ammonium sulfate, or taurocholic acid, to increase the solubility of the antibody and to reduce its reticuloendothelial uptake. The method claimed in U.S. Patent No. 5,151,266 involves preincubation of an antibody with anionic detergent: any unreacted anionic detergent is removed before drug administration.

Current commercial anti-Rh<sub>0</sub>D immune globulin preparations containing  $\leq 0.01\%$  Polysorbate 80 are RhoGAM<sup>®</sup> and MICRhoGAM<sup>®</sup> both produced by Ortho Diagnostics Systems Inc. These preparations must be administered only by intramuscular injection due to relatively high protein aggregation and low product purity (as discussed *supra* for such preparations). Similarly, Polygam<sup>®</sup> and Polygam S/D<sup>®</sup> (Red Cross) contains  $\leq 0.01\%$  Polysorbate 80 to improve immune globulin solubility and storage stability. These products contain relatively low IgG content at 90%.

With respect to the use of surface active agents in the production of immune globulin, U.S. Patent Nos. 4,371,520 and 4,379,086 describes the use of alkylene oxide polymers such as polyethylene glycol in the fractionation process for isolating immune globulin-rich fractions from plasma. Similarly, U.S. Patent Nos. 4,276,283 and 5,132,406 describe the use of alkylene oxide polymers such as polyethylene glycol in a precipitation step for isolating and purifying immune globulin-rich fractions.



- 9 -

The ability of surface active agents to alter the pharmacologic properties of drugs has been examined to a limited extent, but their usefulness in immune globulin formulations in a clinical setting has not been established. Jekunen, A. et al. (*Acta Oncol.* 35: 267-271, 1996) and Kairemo et al. (*Anticancer Res.* 16(6B);3542-3550, 1996) reported the *in vivo* modulation of antibody kinetics in mice by Polysorbate 80. Intra-tumour administration of the non-ionic surface active agent, Polysorbate 80, improved the targeting of a radiolabeled monoclonal antibody to the tumour and accelerated antibody clearance from the blood.

Ellis, A.G. et al. (*Cancer Chemother. Pharmacol.* 38: 81-87, 1996) describes the effects of two surface active agents, Cremophor EL and Tween 80, on the pharmacokinetics of a chemotherapeutic non-protein drug, etoposide, in an isolated perfused rat liver experimental model. Co-administration of either surface active agent decreased the elimination half-life of etoposide. Masters, J.R. et al. (*Cancer Chemother. Pharmacol.* 25: 267-273, 1990) decreased the *in vivo* half-life of the chemotherapeutic drug, thioTEPA in human subjects. These decreases in plasma half-life correspondingly increase the need for more frequent drug administration to maintain effective plasma drug concentrations which in turn increases the cost associated with such therapy in the clinical setting.

Liu, F. and Liu, D. (*Pharm. Res.* 12: 1060-1064, 1995) demonstrated the ability of Polysorbate 80 to attenuate the clearance of parenterally administered oil-in-water emulsions. Such oil-in-water emulsions are physicochemically and biochemically different from the immune globulin proteins of the present invention.

The benefits and methods for covalent bonding of amphipathic polymer moieties to proteins are known in the art. For example, the chemical conjugation of polyethylene glycol (PEG) or monomethoxy-polyethylene glycol (MPEG) to a variety of proteins by a variety of different methods has been described (see PCT Patent Application GB94/01844 published as WO 95/06058; U.S. Patent No. 5,349,052; Delgado, C. et al., *Crit. Rev. Ther. Drug Carrier Sys.* 9: 249-304,

- 10 -

1992). One of the major observed advantages of PEG conjugation to a protein is to decrease its rate of clearance from the body and to increase plasma half-life. However, the polymer (MPEG) by itself without conjugation was shown to elicit no effect on the plasma half-life of proteins.

#### SUMMARY OF THE INVENTION

Immune globulin preparations with novel clinical characteristics and benefits are presented. Immune globulin preparations of the present invention contain an immune globulin with relatively high IgG and low aggregated protein contents and are suitable for intravenous injection or infusion. The immune globulin preparation contains one or more non-ionic surface active agents in a physiologically compatible buffered medium. Inclusion of one or more such non-ionic surface active agents in the preparation surprisingly prolongs the serum half-life of the immune globulin *in vivo* and improves the safety profile of the product. An immune globulin preparation with an increased serum half-life is clearly advantageous and contrary to the teachings of the prior art. A preparation with an extended half-life means that the active therapeutic ingredient would have a longer survival time in the bloodstream to exert its desired therapeutic effect. A longer serum survival time would also allow for a reduced frequency of drug administration. This results in a more convenient dosing schedule with fewer injections which thereby improves patient compliance. A consequence is to reduce indirect costs associated with parenteral administration of the drug. Moreover, a longer serum survival time of a time may translate into the requirement of smaller maintenance doses to maintain an effective serum drug concentration thereby minimizing the direct cost of drug therapy.

In one aspect, the present invention provides an immune globulin preparation comprising an immune globulin and a non-ionic surface active agent, where the non-ionic surface active agent is in a concentration sufficient to increase the serum half-life of the immune globulin. The immune globulin preparation may have more than one

- 11 -

non-ionic surface active agent, so long as the non-ionic surface active agents are in a concentration sufficient to increase the serum half-life of the immune globulin.

According to one embodiment, the immune globulin is  
5 anti-Rh<sub>0</sub>D immune globulin wherein the anti-Rh<sub>0</sub>D immune globulin has an IgG purity of greater than 95% and a monomeric protein content of greater than 94%. In a preferred embodiment, the preparation is aqueous.

According to another embodiment, the immune globulin is anti-c immune globulin which has an IgG purity of greater than 95%  
10 and a monomeric protein content of greater than 94%.

According to another embodiment, the preparation has a concentration of the immune globulin of about 2 weight percent to about 10 weight percent.

The non-ionic surface active agent may be a sorbitan ester  
15 of a fatty acid selected from the group consisting of sorbitan monolaurate, sorbitan monopalmitate, sorbitan monostearate, sorbitan tristearate, sorbitan monooleate and sorbitan trioleate.

The non-ionic surface active agent may also be a polyoxyethylene sorbitan ester of a fatty acid selected from the group  
20 consisting of polyoxyethylene (20) sorbitan monolaurate; polyoxyethylene (4) sorbitan monolaurate; polyoxyethylene (20) sorbitan monopalmitate; polyoxyethylene (20) sorbitan monostearate; polyoxyethylene (4) sorbitan monostearate; polyoxyethylene (20) sorbitan tristearate; polyoxyethylene (20) sorbitan monooleate; polyoxyethylene (5) sorbitan monooleate; and  
25 polyoxyethylene (20) sorbitan trioleate.

According to one embodiment, the preparation will have a concentration of the non-ionic surface active agent of about 0.01 weight percent to about 0.5 weight percent.

According to another embodiment there is provided an  
30 aqueous immune globulin preparation wherein the immune globulin has an increased serum half-life comprising: about 3-8% human anti-Rh<sub>0</sub>D immune globulin with an IgG purity of greater than 95% and a monomeric protein content of greater than 94%; sodium chloride at about

- 12 -

0.25% (w/v); very low level buffer with essentially no ionic strength; Polysorbate 80 at about 0.01% to about 0.5% (w/v); and L-glycine at about 0.1M.

In another aspect, the present invention provides a method  
5 of increasing the serum half-life of an immune globulin comprising administering a preparation comprising an immune globulin and a non-ionic surface active agent in a physiologically acceptable medium to an animal in need thereof.

In yet another aspect, the present invention provides a  
10 method of reducing the elevation of neutrophil counts in a recipient comprising administering a preparation comprising an immune globulin and a non-ionic surface active agent in a physiologically acceptable medium to an animal in need thereof. According to either method the immune globulin preparation may be administered intravenously.

In all cases, the preparation possesses the novel  
15 characteristic of an extended serum half-life *in vivo* and reduced immunogenicity in comparison with equivalent immune globulin preparations not containing the non-ionic surface active agent.

A preparation according to the present invention may be in  
20 the format of a liquid formulation or may be lyophilized to form a powder formulation. The liquid formulation may be administered directly, while the lyophilized powder format may be reconstituted in a physiologically compatible medium before drug administration.

In an embodiment, the immune globulin in a preparation  
25 of the present invention is a human immune globulin prepared by extraction from human plasma using conventional cold ethanol fractionation method followed by a method to render the preparation suitable for intravenous administration or by chromatographic procedures. The immune globulin or binding partner may also be a  
30 monoclonal antibody or binding partner produced by recombinant DNA or hybridoma technology.

In another embodiment, the immune globulin in a preparation of the present invention is an anti-D (also known as anti-Rh<sub>0</sub>

- 13 -

or anti-Rh<sub>0</sub>D) immune globulin; an anti-C (also known as anti-rh') immune globulin; an anti-E (also known as anti-rh'') immune globulin; an anti-c (also known as anti-hr') immune globulin or anti-e (also known as anti-hr'') immune globulin. This immune globulin may be prepared  
5 by conventional cold ethanol fraction followed by a method to render the preparation suitable for intravenous administration, by chromatographic techniques or by recombinant DNA or hybridoma technology.

Another aspect of the invention provides a method of extending the serum half-life or altering the immunomodulatory effect of  
10 and immune globulin comprising the addition of a sufficient amount of one or more non-ionic surface active agents to the immune globulin formulation. The immune globulin may a human immune globulin extracted from plasma using conventional ethanol fractionation followed by a method to render the preparation suitable for intravenous  
15 administration, by chromatographic methods, or it may be a monoclonal antibody or binding partner produced by recombinant DNA or hybridoma technology. More specifically, the immune globulin may be an anti-D (also known as anti-Rh<sub>0</sub> or anti-Rh<sub>0</sub>D) immune globulin; an anti-C (also known as anti-rh') immune globulin; an anti-E (also known as anti-rh'')  
20 immune globulin; an anti-c (also known as anti-hr') immune globulin or anti-e (also known as anti-hr'') immune globulin.

In a further aspect of the invention, the immune globulin formulation is administered to a mammal by parenteral injection or infusion to elevate circulating immune globulin levels.

25 Other features and advantages of the present invention will become apparent from the following detailed description. It should be understood, however, that the detailed description and the specific examples, while indicating preferred embodiments of the invention, are given by way of illustration only and are not intended to limit, in any  
30 way, the scope of the present invention. As will become apparent to those skilled in the art, various changes and modifications may be made based on the following detailed description, however, all are within the spirit and scope of the present invention.

### **BRIEF DESCRIPTION OF THE DRAWINGS**

The invention will now be described in relation to the drawings in which:

Figure 1 is a graph of mean anti-Rh<sub>0</sub>D immune globulin blood levels after an intramuscular injection of WinRho SD™. Mean serum anti-Rh<sub>0</sub>D immune globulin results are shown for formulations with and without 0.01% (w/v) Polysorbate 80. The solid diamonds show the results from subjects injected with the conventional formulation of WinRho SD™ in 0.9% (w/v) sodium chloride solution. The shaded boxes show the results in subjects injected with new formulation of WinRho SD™ with Polysorbate 80 in 0.9% (w/v) sodium chloride solution.

Figure 2 is a graph of mean anti-Rh<sub>0</sub>D immune globulin blood levels for up to 82 days after an intramuscular injection of WinRho SD™. Mean serum anti-Rh<sub>0</sub>D immune globulin results are shown for formulations with and without 0.01% (w/v) Polysorbate 80. The solid diamonds show the results from subjects injected with the conventional formulation of WinRho SD™ in 0.9% (w/v) sodium chloride solution. The open squares show the results from subjects injected with the formulation of WinRho SD™ with Polysorbate 80 in 0.9% (w/v) sodium chloride solution.

### **DETAILED DESCRIPTION OF THE INVENTION**

As mentioned above, the present inventors have found that the addition of a non-ionic surface active agent to a preparation of an immune globulin favourably alters the pharmacokinetics of the immune globulin as a therapeutic agent. The inclusion of said non-ionic surface active agent in the formulation prolongs the survival time or serum half-life of said immune globulin.

Accordingly, broadly stated, the present invention provides an immune globulin preparation comprising an immune globulin and a non-ionic surface active agent, where the non-ionic surface active agent is in a concentration sufficient to increase the serum half-life of the immune globulin. The immune globulin preparation may have more

- 15 -

than one non-ionic surface active agent, so long as the non-ionic surface active agents are in a concentration sufficient to increase the serum half-life of the immune globulin.

The phrase "surface active agent" means an agent that  
5 reduces surface tension when dissolved in a solution, such as in water or an aqueous solution. The term "surfactant" is synonymous. The phrase "sufficient to increase the serum half-life of the immune globulin" means that the serum half-life of the immune globulin with at least one surface active agent is increased as compared to the serum half-life of the  
10 immune globulin when administered without a surface active agent.

The immune globulin of the present invention can be any immune globulin including IgG (all subclasses), IgA, IgD, IgE, and IgM and includes fragments of the immune globulins such as Fab' and F(ab')<sub>2</sub> fragments. The immune globulin is preferably non-aggregated (over  
15 about 94% monomeric immune globulin) and has a purity of greater than about 95%. More preferably, the immune globulin preparation is in a form suitable for intravenous injection or infusion.

An example of immune globulin that can be used in the present invention is Rh immune globulin or Rh antibodies. Rh  
20 antibodies include anti-D (also known as anti-Rh<sub>0</sub> or anti-Rh<sub>0</sub>D); anti-C (also known as anti-rh'); anti-E (also known as anti-rh''); anti-c (also known as anti-hr') and anti-e (also known as anti-hr''). The Rh antibodies of the present invention may be preparations from plasma enriched for Rh antibodies, polyclonal antibodies, monoclonal antibodies,  
25 antibody fragments (e.g. Fab, and F(ab')<sub>2</sub>), and those produced by recombinant DNA technology. Other immune globulin preparations suitable for intravenous injection or infusion, such as varicella zoster immune globulin (Varitect® by Biotest Pharma) or cytomegalovirus immune globulin (Cytogam® by Connaught), can also benefit from the  
30 present invention.

The inventors have also found that the addition of a non-ionic surface active agent to an immune globulin reduced the elevation

- 16 -

of patient neutrophil counts observed with a conventional immune globulin without the non-ionic surface active agent.

### Immune Globulin Production

Preparations with a high Rh antibody content suitable for intravenous injection or infusion may be isolated as an immune globulin fraction from plasma, preferably human plasma, using conventional techniques. For example, they may be isolated using: (a) the Cohn cold ethanol fractionation method or modifications thereto (see Huchet, J. et al., *Rev. Fr. Transfus.* 13:231, 1970; Chown, B. et al., *Can. Med. Assoc. J.* 100:1021, 1969; Jouvenceaux, A. et al., *Rev. Fr. Transfus.* 12 (suppl.): 341, 1969; Barandun, S. et al., *Vox Sang.* 7: 157-174, 1962); (b) ion-exchange chromatographic methods (e.g. using DEAE-Sephadex) and modifications thereto may be used to produce Rh antibodies of higher product yield and quality (Cunningham, C.J. et al., *Biochem. Soc. Trans.* 8: 178, 1980; Hoppe, H.H. et al., *Vox. Sang.* 25: 308, 1973; Hoppe, H.H. et al., *Münch. Med. Wochenschr.* 109: 1749, 1967; Baumstark, J.S. et al., *Arch. Biochem.* 108:514, 1964); and/or (c) anion-exchange chromatographic method as taught in Canadian Patent No. 1,201,063, and modifications thereto. Commercially available anti-Rh<sub>0</sub>D immune globulin preparations may also be used in the methods. For example, anti-Rh<sub>0</sub>D preparations such as WinRho® or WinRho SD® (Cangene Corporation) may be used in the present invention.

In an embodiment of the invention, an anti-Rh<sub>0</sub>D immune globulin fraction is prepared by contacting an aqueous plasma fraction containing IgG with one or more chromatographic separation columns to produce a purified IgG-rich fraction. The aqueous plasma fraction used in the process may be normal non-immunized plasma from an animal source, preferably a human source, or hyperimmune plasma such as plasma from Rh alloimmunized donors.

For example, Rh<sub>0</sub>D antigen is used to immunize an animal through intramuscular, subcutaneous, intraperitoneal, or intraocular injection, with or without an adjuvant such as Freund's complete or incomplete adjuvant. With the option of booster



immunizations, samples of serum are collected and tested for reactivity to the antigen in standard assays (described below). Particularly preferred is polyclonal antisera which will give a signal on one of the assays that is at least three times greater than background. Once the titre of the animal  
5 has reached a plateau in terms of antigen reactivity, larger quantities of the antisera may be obtained readily either by periodic bleeding or by exsanguinating the animal.

Human anti-Rh<sub>0</sub>D immune globulin may also be produced in human volunteers. For example, an anti-Rh<sub>0</sub>D immune globulin  
10 preparation may be obtained from a subject who is naturally immunized (e.g. from an Rh incompatible pregnancy) or artificially immunized using Rh-positive blood cells or Rh<sub>0</sub>D antigen.

Anti-Rh<sub>0</sub>D immune globulin-containing plasma collected from animal or human is modified to the ionic strength and pH of the  
15 initial buffer used with a chromatographic separation column. According to one embodiment of the invention, an aqueous animal plasma fraction is contacted with one or more, preferably one to two, anionic exchangers to produce a purified IgG-rich fraction.

By way of example, an aqueous animal or human plasma  
20 fraction is applied to an anion exchange column which may contain an agarose cross-linked anionic exchange resin such as DEAE-Sephacrose CL6B, TMAE Fractogel or DEAE Sephadex A-50. An IgG-rich fraction is obtained from the column by eluting with an equilibrating buffer. The IgG-rich fraction may be concentrated, for example, by ultrafiltration.

25 The purified IgG protein may optionally be treated with a solvent and detergent to inactivate lipid envelope viruses. Suitable solvents and detergents which may be used include Triton X-100 and tri(n-butyl) phosphate (Horowitz, B., *Curr. Stud. Hematol. Blood Transfus.* 56: 83-96, 1989). After this process, the solvents and detergents  
30 may be removed using conventional methods such as reverse phase chromatography.

Monoclonal immune globulins may also be readily produced using recombinant and hybridoma techniques (see Canadian

Patent number 1,303,534; Canadian Patent number 1,303,533; European Patent Application 87302620.7 published as EP 239,400; European Patent Application 93102609.0 published as EP 557,897; Fletcher, A. and Thompson, A., *Transfus. Med. Rev.* 9: 314-326, 1995; Alting-Mees, M. et al., *Strat. Mol. Biol.* 3: 1-9, 1990; Huse, W.D. et al., *Science* 246: 1275-1281, 1989; Sastry, L. et al., *Proc. Natl. Acad. Sci. USA* 86: 5728-5732, 1989). Similarly, binding partners or domains may be constructed using recombinant DNA techniques to incorporate the variable regions of a gene encoding a specific antibody (see PCT Patent Application PCT/GB93/00605 published as WO 93/19172; PCT Patent Application PCT/GB93/02492 published as WO 94/13804; PCT Patent Application PCT/EP90/01964 published as WO 91/07492; Bird et al., *Science* 242: 423-426, 1988). It will be apparent to one skilled in the art that fractionation and recombinant approaches may be applied to diverse types of immune globulins. For example, specific monoclonal immune globulins against different antigens may be generated by techniques based on the same principle of recombinant DNA technology.

#### **Non-Ionic Surface Active Agents**

Non-ionic surface active agents of the present invention can be any agent that can prolong the serum half-life of an immune globulin. Preferably, the surface active agent is of the Tween® or Span® type surface active agents.

Span® type agents are partial esters of common fatty acids and sugar alcohol anhydrides derived from sorbitol. The common fatty acids derived from sorbitol are preferably lauric acid, palmitic acid, stearic acid or oleic acid derived from sorbitol. For example, Span 20 is sorbitan monolaurate, Span 40 is sorbitan monopalmitate, Span 60 is sorbitan monostearate, Span 65 is sorbitan tristearate, Span 80 is sorbitan monooleate, and Span 85 is sorbitan trioleate.

Tween® type agents are derivatives of Span® products with polyoxyethylene chains attached to non-esterified hydroxyl groups. The common fatty acids derived from sorbitol are preferably lauric acid, palmitic acid, stearic acid or oleic acid derived from sorbitol. For example,

Tween 20 is polyoxyethylene (20) sorbitan monolaurate, Tween 21 is polyoxyethylene (4) sorbitan monolaurate, Tween 40 is polyoxyethylene (20) sorbitan monopalmitate, Tween 60 is polyoxyethylene (20) sorbitan monostearate, Tween 61 is polyoxyethylene (4) sorbitan monostearate, Tween 65 is polyoxyethylene (20) sorbitan tristearate, Tween 80 is polyoxyethylene (20) sorbitan monooleate, Tween 81 is polyoxyethylene (5) sorbitan monooleate, and Tween 85 is polyoxyethylene (20) sorbitan trioleate.

Non-ionic surface agents such as sorbitan esters or polyoxyethylene sorbitan esters of fatty acids may be prepared by methods well known in the art. Such surface active agents may also be obtained commercially from J.T. Baker Inc. (Phillipsburg, New Jersey, USA), ICI Atkemix (Brantford, Ontario, Canada), Van Waters and Rogers Ltd. (Richmond, British Columbia, Canada), or Nikkol Co. (Japan).

#### **15 Immune Globulin Preparation**

Formulation of anti-Rh<sub>0</sub>D immune globulin of the present invention involves the addition of an amount of a non-ionic surface active agent sufficient to extend the serum half-life or to alter the immunomodulatory effect of the immune globulin to the IgG-rich concentrate obtained as described above. The immune globulin preferably is at least about 95% pure, more preferably about 99.5% pure, contains at least 94% monomeric IgG, and has not been subjected to chemical or enzymatic modification. A preferred non-ionic surface active agent is Polysorbate 80 which is added to a final concentration of about 0.01% to about 0.5%. Sodium chloride may be added to the formulation to a final concentration of up to about 0.9%. An additional stabilizing agent such as L-glycine or L-histidine may be added to a final concentration of about 0.025M to 0.05M. A preferred preparation contains the following: a pharmacologically effective amount of human anti-Rh<sub>0</sub>D immune globulin (about 3-8%); sodium chloride at about 0.25% (w/v); no or very low level buffer with essentially no ionic strength; Polysorbate 80 at a concentration of about 0.01%-0.02% (w/v); and L-glycine at a concentration of about 0.1M.

- 20 -

The anti-Rh<sub>0</sub>D immune globulin formulation is aseptically filtered again through a 0.22 micron filter and put into vials or ampoules. Filling operations are conducted under aseptic conditions and the fill volume per vial is calculated so that each vial contains a pharmacologically effective amount of anti-Rh<sub>0</sub>D immune globulin. This specific amount or volume can vary depending upon the intended route of administration and therapeutic use. The target filling volume is also calculated with sufficient excess to allow for variation in the potency assay and/or possible loss of potency during storage.

10 The final aqueous formulation may be lyophilized using a Virtus 251 SRC-5 Sublimator (or equivalent). Lyophilization (also termed vacuum freeze-drying or sublimation) is commonly used in the manufacture of protein pharmaceuticals to improve the stability of the product and extend its shelf life. The lyophilization process is often  
15 described as being divided into three stages: freezing; primary drying (also termed ice sublimation); and secondary drying (also termed water desorption). The starting aqueous solution containing the protein is frozen and the ice is subsequently sublimed thereby leaving a dry porous mass of protein which is stable and can be reconstituted rapidly in water.  
20 The technical parameters of the lyophilization process including temperature (eutectic and collapse), vacuum pressure and atmospheric gas composition, are fully automated by the Virtus 251 SRC-5 Sublimator. The basic theories and more practical aspects of protein lyophilization and formulation are described in detail in Skrabanja, A.T. et al. (*J. Pharm. Sci. Technol.* 48: 311-317, 1994); Rey, L.R. (*Dev. Biol. Stand.* 74: 3-8, 1992); Pikal, M.J. (*BioPharm* October, 26-30, 1990); Pikal, M.J. (*J. Parenter. Sci. Technol.* 39: 115-138, 1985); Williams, N.A. and Polli, G.P. (*J. Parenter. Sci. Technol.* 38: 48-59, 1984; Nail, S.L. (*J. Parenter. Drug Assoc.* 34: 358-368, 1980); Ito, K. (*Chem. Pharm. Bull.* 19: 1095-1102, 1971).

30 In the case of a lyophilized powder formulation, the powder comprising the immune globulin and the non-ionic surface active agent is reconstituted in a physiologically compatible diluent such as sterile water for injection or saline before parenteral administration.

- 21 -

For example, 120 ug (600 IU) or 300 ug (1,500 IU) of a commercial anti-Rh<sub>0</sub>D immune globulin product, WinRho SD™, is reconstituted in 2.5 mL diluent.

#### Therapeutic dosage of immune globulin preparation

- 5                    Dosages of anti-Rh<sub>0</sub>D immune globulin in formulations of the present invention depend on individual needs, on the protein content/concentration of the immune globulin preparation, on the desired effect in a particular therapeutic indication, and on the chosen route of drug administration. Daily dosages of an anti-Rh<sub>0</sub>D immune
- 10 globulin preparation (3% to 8% wt-solution) for humans by intramuscular or intravenous injection generally vary between about 50 IU (10 ug) to 2,000 IU (400 ug) per kg body weight. For intramuscular injection, the preferred dosage is about 100 IU (20 ug) to 2,000 IU (400 ug) per kg body weight. For intravenous injection, the preferred dosage is
- 15 about 50 IU (10 ug) to 1,000 IU (200 ug) per kg body weight, preferably 250 IU ( 50 ug) per kg body weight. The recommended dosage of Biotest Pharma's intravenous varicella zoster immune globulin preparation, Varitect®, is about 50 IU per kg body weight for shingles therapy and are lower (about 12 to 25 IU per kg body weight) for chickenpox prophylaxis.
- 20 In contrast, the recommended dosages of general intravenous immune globulin products (4.5-5.5 wt-% solution) such as Gamimune®, Iveegam® or Sandoglobulin® are significantly higher at about 100 mg to 800 mg per kg body weight.

#### EXAMPLES

##### 25 EXAMPLE 1

**Pharmacokinetics of anti-Rh<sub>0</sub>D immune globulin given as Polysorbate 80 formulation over a period of 30 days**

- Methods. The Pharmacokinetics of anti-Rh<sub>0</sub>D immune globulin formulations with and without Polysorbate 80 were assessed in a single-
- 30 centre, randomized, parallel arm study. Twenty-four human subjects (normal, healthy male and female volunteers of age 18 to 55 years) were randomized into two groups to receive 600 µg (3,000 IU) of a commercial brand of anti-Rh<sub>0</sub>D immune globulin, WinRho SD®. Twelve subjects

- 22 -

received the conventional WinRho SD® formulation without Polysorbate 80, and the other 12 subjects received the WinRho SD® formulation with 0.01% (w/v) Polysorbate 80. Each formulation was given intramuscularly as two 1.25 mL injections with the test articles  
5 being lyophilized human anti-Rh<sub>0</sub>D immune globulin in 0.9% (w/v) saline for intravenous injection with or without Polysorbate 80.

Screening assessments were conducted within three weeks of drug administration. Baseline assessments were conducted on the morning of the day that WinRho SD™ was administered to the subjects  
10 and before drug administration. These included haematology, blood chemistry and urinalysis. Demographics, vital signs and baseline laboratory tests were compared for study subjects randomized to the different arms of treatment. There was no statistically significant difference between the two treatment groups in any assessments prior to  
15 drug administration.

Subjects remained under observation for eight hours and blood samples for anti-Rh<sub>0</sub>D immune globulin analysis were drawn from the study subjects to provide 5 mL serum samples at the following times after study drug administration: 8 hours, 24 hours, 3 days, 7 days, 11 days,  
20 14 days, 21 days, and 28 days. Subjects also underwent haematology, blood chemistry and urinalysis laboratory testing at 7 days and 28 days after WinRho SD™ injection. Anti-Rh<sub>0</sub>D immune globulin concentration in patient samples was analyzed by conventional techniques (see Auto-Analyzer technique in Moore, B.P.L., *Can. Med. Assoc. J.* 100: 381-387,  
25 1969).

Pharmacokinetics. Regressions were performed on log transformed corrected serum anti-Rh<sub>0</sub>D immune globulin levels against time to determine lambda and subsequently, the estimated half-life of drug in the study subjects. Blood levels after the day 3 draw were used in these  
30 regressions as peak serum levels of anti-Rh<sub>0</sub>D immune globulin were usually obtained by day 3 after injection of drug. Significant linear relationships ( $p < 0.02$ ) existed between the variables Log (corrected anti-Rh<sub>0</sub>D immune globulin) and Time for all study subjects.

- 23 -

The mean time to peak anti-Rh<sub>0</sub>D immune globulin levels after intramuscular injection of 600 µg of WinRho SD™ was about 3 days and peak serum anti-Rh<sub>0</sub>D immune globulin levels that were achieved were about 70 ng/mL. There was no statistically significant difference  
 5 between the two formulations and the mean time to peak or peak levels of drug. Similarly, the AUC<sub>28 day</sub> was about 1250 days•ng/mL and there was no difference between the two formulations in these values.

The mean half-life was different for the two formulations of WinRho SD™. The formulation of drug without Polysorbate 80 had a  
 10 mean apparent serum half-life of  $16.4 \pm 3.8$  days, while the mean apparent half-life in subjects whom received the formulation with Polysorbate 80 was  $20.3 \pm 3.4$  days. This difference is statistically significant ( $p=0.012$ ) in a Student t test of the difference between means. Key pharmacokinetic data are presented in Table 1.

15

TABLE 1			
	Formulation without Polysorbate 80	Formulation with Polysorbate 80	Significance
Time to Peak (days) Mean $\pm$ SD Median Range	$2.83 \pm 0.14$ 3.00 1.00 - 3.04	$3.65 \pm 1.55$ 2.99 2.96 - 6.99	$p=0.100$
Peak Anti-D (ng/mL) Mean $\pm$ SD Median Range	$76.2 \pm 12.2$ 79.7 54.76 - 99.09	$68.8 \pm 11.8$ 68.8 49.28 - 88.39	$p=0.157$
AUC (days•ng/mL) Mean $\pm$ SD Median Range	$1225 \pm 195$ 1278 938 - 1564	$1273 \pm 268$ 1174 982 - 1803	$p=0.673$
Serum Half-Life (days) Mean $\pm$ SD Median Range	$16.4 \pm 3.6$ 17.0 9.04 - 21.91	$20.3 \pm 3.4$ 20.6 15.07 - 26.74	$P=0.012$

**Pharmacokinetics of anti-Rh<sub>0</sub>D immune globulin given as Polysorbate 80 formulation over a period of 84 days.**

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5 mL serum samples were also collected from the same subjects on 42, 56 and 84 days post injection and serum anti-Rh<sub>0</sub>D immune globulin levels were determined for up to 84 days post administration of WinRho SD™.

Individual subject pharmacokinetics are presented in Table 2. The slope from the regression of log (corrected anti-D) on actual time after injection of WinRho SD (up to day 84) data was included in the regression analysis.

TABLE 2						
Subject	Time to Peak (Days)	Peak Anti-D (ng/mL)	Corrected Peak Anti-D (ng/mL)	$\lambda$ (/day)	$t_{1/2}$ (days)	AUC (days•ng/mL)
WinRho SD™ Formulation (without Polysorbate 80)						
SS02	3	91.54	83.22	0.040118	17.278	1940.45
SS03	3	80.04	72.76	0.040598	17.073	1853.01
SS05	1	88.67	79.06	0.028732	24.125	2544.84
SS06	2.99	89.3	81.18	0.050862	13.628	1135.8
SS08	2.98	62	56.36	0.033751	20.537	1597.15
SS10	3	55.42	54.76	0.032355	21.423	1435.6
SS14	2.98	86.74	78.85	0.035784	19.37	1979.34
SS16	2.96	66.71	70.19	0.035764	19.381	1489.86
SS18	2.99	95.05	99.09	0.036003	19.252	2263.9
SS19	3.03	85.31	84.67	0.029916	23.17	2034.25
SS20	3.04	80.59	81.04	0.040478	17.124	1866.07
SS22	3	74.15	71.41	0.042734	16.22	1600.78
WinRho SD™ Formulation (with Polysorbate 80)						
SS01	3	82.8	75	0.031157	22.247	2131.76
SS04	3.08	66.56	60.29	0.027221	25.464	1769.77
SS07	6.97	88.32	80	0.018439	37.591	3043.64
SS09	2.96	77.23	69.95	0.031561	21.962	1759.42
SS11	2.96	82	74.28	0.033716	20.558	1986.99
SS12	6.99	97.58	88.39	0.02761	25.105	2963.95
SS13	3	91.59	82.96	0.035027	19.789	2300.9
SS15	2.96	74.57	67.55	0.028825	24.047	1998.26
SS17	2.96	62.85	56.93	0.033925	20.432	1702.44
SS21	2.98	71.01	64.32	0.033193	20.882	1710.56
SS23	2.99	62.97	57.04	0.030317	22.863	1679.9
SS24	2.98	54.41	49.28	0.024491	28.302	1737.46



Mean peak values of anti-Rh<sub>0</sub>D immune globulin levels were  $79.6 \pm 12.6$  ng/mL for the conventional formulation and  $76.0 \pm 13.0$  ng/mL for the new formulation which are not significantly different ( $t = -0.69603$ ;  $p = 0.4937$ ). Mean time-to-peak values were  $3.65 \pm 2.56$  days for the conventional formulation and  $2.83 \pm 0.58$  days for the new formulation which are not significantly different ( $t = -1.71648$ ;  $p = 0.10012$ ). Similarly, mean area under the curve (AUC<sub>84 day</sub>) values were  $1811.8 \pm 385.3$  days for the conventional formulation and  $2065.4 \pm 479.6$  days.ng/mL for the new formulation which are not significantly different ( $t = -1.4284$ ;  $p = 0.16722$ ). Conversely, the mean apparent half-life values for the two WinRho SD™ formulations were different. The formulation of drug without Polysorbate 80 had a mean apparent serum half life of  $19.1 \pm 3.00$  days, while the corresponding value for the drug formulation with Polysorbate 80 was  $24.1 \pm 4.9$  days ( $t = -3.03582$ ;  $p = 0.006$ ).

#### Safety Of Administration

Twenty-four subjects completed 28 days of participation in this study and no subject was withdrawn because of adverse experience. There were a total of 33 adverse events reported in this study (see Table 3). The majority of the events occurred in the Body As A Whole (13 events) and the Respiratory System (9 events). For the most part, the events were evenly distributed between the two different arms of treatment. An exception was 3 adverse events that occurred in the Digestive System: two reports of dyspepsia and one report of vomiting occurred in subjects receiving WinRho SD™ without polysorbate 80. However, since none of the events that occurred in the Digestive System were believed to be related to the WinRho SD™ injection, this observation is not considered significant.

TABLE 3						
Preferred Term	All Reports		Formulation without Polysorbate 80		Formulation with Polysorbate 80	
	# Events	# (%)	# Events	# (%)	# Events	# (%)
BODY AS A WHOLE	13	13 (54%)	6	6 (50%)	7	7 (58%)
CARDIOVASCULAR SYSTEM	1	1 (4%)	0	0	1	1 (8%)
DIGESTIVE SYSTEM	3	3 (12%)	3	3 (25%)	0	0
NERVOUS SYSTEM	3	3 (12%)	2	2 (17%)	1	1 (8%)
RESPIRATORY SYSTEM	9	6 (25%)	4	3 (25%)	5	3 (25%)
SPECIAL SENSES	2	2 (8%)	0	0	2	1 (17%)
UROGENITAL SYSTEM	2	1 (4%)	2	1 (8%)	0	0

On the morning of study drug administration and before drug injection, a baseline assessment was conducted which included Vital Signs. The Vital Signs were then assessed in study subjects at 1 hour, 3 hour, 8 hour, 24 hour, 7 day and 28 days after drug administration. There were no statistically significant changes in group Vital Signs from baseline and all mean group changes in Vital Signs were within a standard deviation of zero. The largest changes in vital signs relative to the variance was in the temperature of the subjects receiving WinRho SD™ without polysorbate 80 at early times after drug administration. Body temperature was elevated by  $0.3 \pm 0.4$  °C at 1 hour,  $0.3 \pm 0.3$  °C at 3 hours and  $0.5 \pm 0.5$  °C at 8 hours after WinRho SD™ injection compared to increases in this group of  $0.2 \pm 0.4$  °C at 24 hours,  $0.1 \pm 0.6$  °C at 7 days and  $0.1 \pm 0.4$  °C at 28 days after drug administration. In contrast, the study subjects who received WinRho SD™ with polysorbate 80 had body temperature increases of  $0.0 \pm 0.5$  °C,  $0.1 \pm 0.5$  °C,  $0.2 \pm 0.5$  °C,  $0.0 \pm 0.4$  °C,  $0.1 \pm 0.7$  °C and  $0.1 \pm 0.4$  °C at the assessments after drug administration. Given the low statistical significance to these changes in body temperature, it is not clear if they are related to WinRho SD™ administration. If they are, then the changes are subclinical and the pyrogenic effect is smaller with the new formulation of WinRho SD™, i.e., WinRho SD™ with polysorbate 80.

On the morning of study drug administration and before drug injection, a baseline assessment was conducted that included

- 27 -

laboratory testing. These laboratory tests were repeated in study subjects at 7 days and 28 days after injection of WinRho SD™. Day 7 laboratory data was not significantly different from baseline data and mean  $\Delta$  parameter values were within a standard deviation of zero. However, the mean neutrophil count for the patients receiving the conventional, or old formulation, i.e., WinRho SD™ without polysorbate 80, was  $4.67\% \pm 4.72\%$  seven days after drug administration and this change was statistically different ( $p=0.040$ ) from the mean increase of  $-0.75\% \pm 7.20\%$  in neutrophils 7 days after administration of the new formulation of WinRho SD™. This difference accounted, in part, for the differences between arms in the proportion of WBC that were neutrophils (61% vs. 53%) and in the bands ( $4.44 \times 10^9/L$  vs.  $3.07 \times 10^9/L$ ) at 7 days after drug administration.

There are no statistically significant differences in treatment arms in the haematology laboratory data obtained 28 days after drug administration. There was an overall decrease of 1.3% in the haematocrit of the study subjects 28 days after WinRho SD™ that may have been related to the frequent phlebotomy associated with participation in the study.

There were differences in the 7 day  $\Delta$ ALT and  $\Delta$ Bilirubin with data from the subjects receiving new formulation being closer to baseline values than data from subjects receiving old formulation. However, the mean differences reflected subclinical changes and there were no differences in mean ALT and mean Bilirubin data for these groups. As such, these differences were believed to be fortuitous and result from the frequent hypothesis testing in this analysis. There were no statistically significant differences between the treatment arms in the clinical chemistry data obtained 28 days after study drug administration.

Conclusion. The formulation of WinRho SD™ that contains Polysorbate 80 had the same, or a better, safety profile as the currently licensed WinRho SD™. This is consistent with the relatively high LD50 values for non-ionic surface active agents in mammals (*supra.*). This new formulation also improved the appearance and stability of WinRho SD™

- 28 -

when reconstituted. Surprisingly, the formulation with Polysorbate 80 has a longer half-life (20.3 days) than the formulation without Polysorbate 80 (16.4 days). This difference is beneficial in the therapeutic use of the drug. For example, the new WinRho SD™ formulation with Polysorbate 80 leads to higher passive anti-Rh<sub>o</sub>D immune globulin levels for long times after drug administration in prophylaxis of Rh Immunization of Rh negative patients. Moreover, inclusion of Polysorbate 80 in the anti-Rh<sub>o</sub>D immune globulin preparation significantly minimized drug-induced elevations of neutrophil counts in the recipients and altered the immunomodulatory effect of the immune globulin.

While the present invention has been described with reference to what are presently considered to be preferred examples, it is to be understood that the invention is not limited to the disclosed examples. To the contrary, the invention is intended to cover various modifications and equivalents included within the spirit and scope of the appended claims.

All publications, patents and patent applications are herein incorporated by reference in their entirety to the same extent as if each individual publication, patent or patent application was specifically and individually indicated to be incorporated by reference in its entirety.